Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HIGHPOINT PHARMACY

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

MFDR Tracking Number
M4-06-1532-01

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
October 25, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In accordance with Rule 134.202 (c) (6) products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions and values assigned for services involving similar work and resource commitments. The carrier has reimbursed zero dollars for this item which is neither fair nor reasonable. We have billed the Carrier our usual and customary rate and have provided the Carrier with examples of audit sheets and/or copies of checks where other carriers in this area have established the $50.00 charge for the reacher/grabber as a fair and reasonable amount as the Commission has not established a MAR for this procedure."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Response Submitted by: S. Rhett Robinson, Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2005	Durable Medical Equipment – Reacher	$50.00	$50.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
4. 28 Texas Administrative Code §133.301 sets out requirements for retrospective review of medical bills.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – Documentation submitted does not substantiate unusually costly and unusually extensive services. Please provide documentation including, but not limited to, documentation of cost, medical records, invoices and itemized statement. (X466)
   - * – Our position remains the same. If you disagree with our decision, please contact the TWCC Medical Dispute Resolution. (X257)

Findings

1. The carrier has asked the Division to dismiss this dispute, stating, "It appears from the MDR submission that all that the provider submitted was the original bill stamped 'REQUEST FOR RECONSIDERATION' and the EOB. Accordingly, that the request was not complete and fails to satisfy the prerequisite for medical dispute resolution. This matter is not ripe for review and should be dismissed pursuant to 28 TAC 133.307(m)(3)." Former 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration." Additionally, §133.307(e)(2)(B) requires that the request shall include "a copy of each explanation of benefits (EOB);" and further, §133.307(g)(3)(A) requires the requestor to send "documentation of the request for and response to reconsideration." Review of the submitted documentation finds a copy of the medical bill submitted to the carrier for reconsideration, a copy of both the initial and reconsideration EOBs, as well as a copy of the provider's reconsideration request letter, with a mail return receipt signed by the insurance carrier acknowledging delivery on September 30, 2005 (the same date of receipt indicated on the reconsideration EOB). The Division notes that the request for reconsideration letter contains a claim-specific substantive explanation of the provider's position, which the Division finds to be more than a mere generic statement. Accordingly, the Division concludes that the respondent's motion for dismissal is without merit. The motion is therefore denied.
2. The respondent's supplemental position statement asserts that "This item does not qualify for reimbursement as it is not meet the definition of 'medical benefit' under Tex. Labor Code sec. 401.011(31)." Per 28 Texas Administrative Code §133.307(j)(2), effective January 1, 2003, 27 *Texas Register* 12282, "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented this denial reason to the requestor prior to the date that the request for medical dispute resolution was filed with the Division; consequently, the respondent has waived the right to raise this new defense. Accordingly, this newly raised denial reason or defense shall not be considered in this review.
3. The insurance carrier denied disputed services with reason code 1 – "Documentation submitted does not substantiate unusually costly and unusually extensive services. Please provide documentation including, but not limited to, documentation of cost, medical records, invoices and itemized statement. (X466)" Per 28 Texas Administrative Code §133.301(c), effective July 15, 2000, 25 *Texas Register* 2115, "An insurance carrier shall not request documentation on a medical bill unless: (1) the documentation is required in accordance with the Commission fee guidelines or rules in effect for the dates of service." No fee guideline or rule was found to require documentation of unusual costliness or unusual extent to be eligible for reimbursement. The respondent did not provide documentation to support that such documentation was required by Division rules or was necessary to process the bill. Further, review of the submitted documentation finds that the information submitted by the health care provider was sufficient to meet Division documentation requirements and was adequate to process the bill. The insurance carrier's denial reasons are not supported. The disputed item will therefore be reviewed per applicable Division rules and fee guidelines.
4. This dispute relates to durable medical equipment, specifically a 32 inch reacher device billed under procedure code E1399, for which neither CMS nor the Division had established a relative value or payment amount at the time of service. Per 28 Texas Administrative Code §134.202(c)(6), "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." No documentation was found to support that the insurance carrier has assigned a relative value or payment amount for these disputed items. The Division concludes that the insurance carrier has not met the requirements of §134.202(c)(6). Consequently, reimbursement is determined according to the provisions of 28 Texas Administrative Code §134.1, regarding use of the fee guidelines.
5. Former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

6. Texas Labor Code §413.011(d) states that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
7. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "The carrier has reimbursed zero dollars for this item which is neither fair nor reasonable. We have billed the Carrier our usual and customary rate and have provided the Carrier with examples of audit sheets and/or copies of checks where other carriers in this area have established the $50.00 charge for the reacher/grabber as a fair and reasonable amount as the Commission has not established a MAR for this procedure."
   - In support of the requested reimbursement, the requestor submitted eight redacted explanations of benefits from various sample insurance carriers, along with redacted copies of the original bills, sufficient to establish that the sample insurance carriers reimbursed the health care provider $50.00 for the same or similar reacher 32" device provided to patients under similar circumstances and billed under procedure code E1399.
   - The Division finds that the requested reimbursement would not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.
   - In considering the increased security of payment afforded by the Act, the Division concludes that the requested reimbursement would be fair and reasonable, ensure the quality of medical care, and achieve effective medical cost control. Accordingly, the requestor has supported that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that $50.00 is a fair and reasonable rate of reimbursement for the reacher device in dispute.
8. 28 Texas Administrative Code §133.307(j)(1)(E)(iii), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes "a discussion of how the Texas Labor Code and commission rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the respondent has not discussed how the Texas Labor Code and commission rules, including fee guidelines, impact the disputed fee issues. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(iii).
9. 28 Texas Administrative Code §133.307(j)(1)(E)(iv), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes "a discussion regarding how the submitted documentation supports the respondent position for each disputed fee issue." Review of the submitted documentation finds that the respondent has not discussed how the submitted documentation supports the respondent's position for each disputed fee issue. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(iv).
10. 28 Texas Administrative Code §133.307(j)(1)(F), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011 and §§133.1 and 134.1 of this title." Review of the submitted documentation finds that:
    - The respondent's position statement asserts that "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."
    - No documentation was found of any payment for the disputed item.
    - No documentation was found to support that the insurance carrier paid according to applicable fee guidelines.
    - The respondent has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
    - The respondent did not discuss or explain how the amount paid represents a fair and reasonable reimbursement for the reacher device.
    - The respondent did not present documentation of nationally recognized published relative value studies, published commission medical dispute decisions, or values assigned for services involving similar work and resource commitments to support a specific reimbursement amount.

- The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement for the item in dispute.
- The respondent did not explain how the amount paid satisfies the requirements of 28 Texas Administrative Code §134.1.

The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the health care in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(j)(1)(F).

11. The Division concludes that the documentation submitted in support of the payment amount proposed by the requestor is the best evidence of an amount that will achieve a fair and reasonable reimbursement for the item in dispute. By a preponderance of the evidence, the requestor has established that $50.00 is a fair and reasonable payment for the disputed reacher device. This amount is recommended. The insurance carrier has paid $0.00, leaving a balance due to the requestor of $50.00.

Conclusion

After thorough review and consideration of the evidence presented by the parties to this dispute, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $50.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $50.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	April 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.